

# ***NH Medicaid Care Management: CMS Final Rule (CMS-2390-F)***

**SB 553 Commission  
December 9, 2016**



# Agenda

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# Background



# Medicaid Managed Care is Governed by Variety of Authorities

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- State Plan Amendment approved by CMS allows state to mandatorily enroll most NH Medicaid enrollees
- 1915(b) waiver authority approved by CMS allows state to mandate enrollment for all beneficiaries exempted under federal rules
- Federal rules at 42 CFR 438 regulate the state's requirements and obligations regarding consumer protections and experience, quality, program integrity, rate development, and services



# Background and goals of final rule

- On June 1, 2015, CMS issued a notice of proposed rulemaking to modernize the regulatory framework for Medicaid managed care and create alignment with other insurance programs where appropriate.
- CMS published the final rules on May 6, 2016 with an effective date of July 5, 2016. There are individual sections governed by later effective dates throughout the new rule.
- Goals:
  - To strengthen beneficiary experience of care and key beneficiary protections.
  - To support State efforts to advance delivery system reform and improve quality of care.
  - To strengthen program integrity by improving accountability and transparency.
  - To align key Medicaid managed care requirements with other health coverage programs.



# Effective Dates



# Implementation Dates

On April 25, 2016, CMS issued a document that outlines the Implementation dates for the various provisions of the new rule. These dates range from May 6, 2016 to July 1, 2019.

- Effective immediately: Federal financial participation for external quality review. §433.15 and §438.370.
- Effective 60 days after publication (July 5, 2016), for example:
  - IMD exception flexibility
- Effective no later than rating period for contracts starting on or after 7/1/2017, for example:
  - Inspection and audits §438.3
  - Actuarial soundness §438.4
  - Rate development §438.5
  - Medical loss ratio §438.8



# Implementation Dates

- Effective no later than rating period for contracts starting on or after July 1, 2018, for example:
  - Ability to increase or decrease capitation rate by 1.5% without rate certification §438.4
  - Network adequacy standards §438.68
  - Enrollee encounter data §438.818
- Effective no later than July 1, 2018:
  - Managed care quality strategy §438.340
- Effective after CMS guidance:
  - Annual program report §438.66
  - Medicaid managed care quality rating system §438.334



# Beneficiary Experience



# Beneficiary Experience- Information requirements

- States to operate a website to provide specific managed care information including each managed care plan's handbook, provider directory, and formulary.
- States to develop definitions for key terms and model handbook and notice templates for use by the managed care plans.
- Enrollee information must be accessible to people with disabilities and available in locally prevalent non-English languages.
- States and managed care plans may provide required information electronically and in paper format upon request and free of charge.



## Beneficiary Experience- information requirements

- NH DHHS already approves the model handbook and notice templates for use by the managed care plans.
- Enrollee information is currently accessible to people with disabilities and available in locally prevalent non-English languages.
- NH DHHS will be working with the Managed care organizations (MCOs) to confirm that enrollee materials are available in both electronic and paper format when requested, free of charge, and will make the appropriate contract changes to ensure MCO compliance.
- NH DHHS will verify that each MCO has their provider directories and formularies available on each plan's website.



## Beneficiary Experience- enrollment and disenrollment

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- States must establish an independent beneficiary support system that offers choice counseling and information to all enrollees and assistance to enrollees who use long-term services and supports.
- States required to provide notices to explain implications of enrollees' choices as well as disenrollment opportunities.
- NH DHHS currently contracts with Maximus to provide choice counseling and the Department will be reviewing the contract scope to add enrollment in-person functions and to increase choice counseling functions.
- Currently, under NH Medicaid, when a prospective enrollee become eligible for Medicaid, notification is sent out to the individual. NH DHHS will review the current notifications to ensure that they adequately inform individuals of their choices and disenrollment opportunities.



## Beneficiary Experience- managed long-term services and supports (MLTSS)

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- States must establish and maintain a structure for stakeholder engagement in planning and oversight of MLTSS programs.
- Enrollees with LTSS needs must be involved in person-centered treatment and service planning.
- The rule creates for cause disenrollment reason to another plan if institutional, employment, or residential provider leaves enrollee's plan.
- States must have transition plans when a beneficiary moves from FFS to managed care or into a new managed care plan.



# **Network Adequacy and Access to Care**



## Network adequacy and Access to Care

- States to develop and implement time and distance standards for primary and specialty care (adult and pediatric), behavioral health, OB/GYN, hospital, pharmacy and pediatric dental services.
- State to develop and implement network adequacy standards for MLTSS programs, including providers that travel to the enrollee.
- The final rule requires external quality reviewers to validate network adequacy and improves the transparency of quality information.
- Managed care plans must certify network adequacy at least annually.
- NH DHHS will review its contract with the EQRO to determine whether the scope of the contract needs to be amended to account for increased network adequacy review activities.
- NH DHHS will add time and distance standards for OBGYN and pediatric specialists to the managed care contract.



# Short Term IMD Stays



## Short Term IMD stays

- The final rule permits the state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-61, that has a short term stay in an Institution of Mental Disease (IMD):
  - Short term stay is a stay no longer than 15 days within a month.
- “In lieu of services” (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings. The final rule establishes contractual and rate setting requirements for ILOS.
- The Department will amend the MCO contract to permit short term stays at an IMD and clarify that a stay can be up to 30 days if the stay occurs over two months.



# Quality



- The final rule requires states to implement a quality rating system (QRS) for managed care plans and to report plan performance.
- CMS expects to implement the QRS over 5 years.
- States may use the QRS CMS proposes or adopt an alternative with CMS approval.
- Currently, NH Medicaid's transition of care policy addresses care between FFS to MCO and MCO to MCO, and DHHS will be including transition of care policies into the comprehensive quality strategy.
- NH DHHS will develop a comprehensive quality strategy as a living document across all Medicaid programs.
- NH DHHS will participate in the comment period for the QRS CMS proposes and will determine whether to rely on the proposed QRS or develop its own.



# Program Integrity



## Program Integrity

- Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse.
- States must screen and enroll all managed care network providers who are not already enrolled in the state's FFS system.
- Requires managed care contracts to address treatment of recovered overpayments and to take these into account in the rate setting process.
- NH DHHS will analyze its current processes around reviewing MCO subcontractor agreements and provider enrollment to determine whether any changes need to be made to the current enrollment process.



# Payments



## Payment and accountability: actuarially sound capitation rates

- Establishes standards for documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification.
- Permits states to increase/decrease the capitation rate by 1.5% without submission of a new rate certification.
- Permits mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval.
- NH DHHS will build in the new documentation review standards into the managed care contract and review process.



## Payment: Medical loss ratio (MLR) Standard

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- The final rule requires managed care plans to calculate and report their MLR experience for each contract year.
- Actuarially sound rates are set to achieve a MLR of at least 85%.
- States may set a higher standard or impose a remittance requirement.
- NH DHHS will work with its actuary, Milliman, to determine whether the MCOs are meeting the 85% MLR standard and whether a higher standard is needed.



- The final rule provides flexibility for state to have value-based purchasing models, delivery system reform initiatives, or provider reimbursement requirement in the managed care contract.
- The final rule strengthens existing quality improvement approaches.
- Permits states to set min/max network provider reimbursement levels for network providers that provide a particular service.
- Currently the contract with the MCOs require that DHHS will withhold one percent of the MCO capitation payments in each year under the payment reform plan. DHHS will review the payment reform plan and the flexibility provided by the CMS regulations to determine whether any changes will be made.



CMS website on the final rule (CMS-2390-F):

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

